

Schools Can't Do It Alone:

Developing Sustainable Systems of Care for School-Based Behavioral Health in California



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Introduction

Through its *Master Plan for Kids' Mental Health*, California has invested \$4.7 billion in youth mental and behavioral health since the start of the COVID-19 pandemic; many of the investments highlight the important role of schools as partners in addressing the youth mental health crisis (California Governor's Office, 2022). However, almost all of the investments in the *Master Plan* are short term and therefore cannot be counted on to fund longer term strategies to

address student mental and behavioral health needs. But local educational agency (LEA)¹ and school leaders suggest that although students' mental and behavioral health issues were exacerbated by the pandemic, these unmet needs predated the pandemic and will continue for many years, long after state and federal one-time funding to support mental and behavioral health is slated to end (Adelman & Taylor, 2021; Kaufman et al., 2016; Krausen et al., 2023). Such mental and behavioral health needs have been particularly prevalent among adolescents; for example, even in 2019, nearly one in three adolescents (ages 12–17) in California reported symptoms indicating serious psychological distress² (Wright et al., 2021).

In an effort to build systems that are more effective and sustainable for meeting youths' needs, leaders within California's education, health care, and social services sectors have begun working together to promote the development of *integrated school-based systems of care*. Through cross-sector collaboration, integrated school-based systems of care can provide comprehensive, aligned, and accessible services that promote whole-child development and advance equity for students and families (Breaking Barriers et al., 2022). Accordingly, some of California's investments within the *Master Plan*, such as the Community Schools Partnership Program (CCSPP) and the Student Behavioral Health Incentive Program (SBHIP), explicitly aim to advance cross-sector collaboration to support school-based services.

Now that the state's short-term behavioral health investments have been underway for several years, this brief summarizes WestEd's recent research investigating how well these investments are aligned with (a) LEAs' highest priority needs for supporting students' mental and behavioral health and (b) the state's goal of advancing integrated school-based systems of care to support students' needs in the long term. Based on the findings reported here, this brief includes recommendations for how state and county leaders can maximize the effectiveness of future investments, further advance integrated school-based systems of care, and incentivize active involvement from health care partners.

WestEd researchers also investigated the areas in which LEAs may need more technical assistance (TA) to establish or advance integrated school-based systems of care. These areas include, for example, finding local cross-sector partners, establishing memoranda of understanding (MOUs) with partners, and setting up systems for data sharing. The researchers also explored the extent to which TA is already available in these areas but may be difficult for some LEAs to find or access. This topic is explored at greater length in a companion brief, [Schools Can't Do It Alone: Envisioning a Statewide System of Support to Advance School-Based Behavioral Health in California](#). Specifically, the brief envisions how a statewide system of support for behavioral health TA might be structured.

¹ LEA refers to a local entity involved in public education, including but not limited to a school district, county office of education, direct-funded charter school, and special education local plan area (SELPA). In the context of this brief, references to LEAs refer primarily to school districts.

² *Serious psychological distress* is a measure of mental health, based on the number and frequency of symptoms reported in the past year, that indicates a serious, diagnosable mental health disorder warranting mental health treatment.

Data Sources

The research team leveraged the following data sources:

- » **Data from interviews with 45 state and national experts on behavioral health and school-based systems of care.** Interviewees included leaders from government agencies, major nonprofits, policymaking bodies, health care organizations, and academia. These interviews were conducted by Breaking Barriers to inform its recent working paper, *California's Children and Youth Behavioral Health Ecosystem* (Breaking Barriers California, 2023).
- » **SBHIP needs assessments and project plans from nearly 60 LEAs, representing 28 counties.** The SBHIP has provided more than \$389 million over a 3-year period (January 1, 2022, through December 31, 2024) for targeted interventions aimed at increasing access to school-affiliated behavioral health services for TK–12 students in public schools. In the application process, county offices of education (COEs), in collaboration with their participating LEAs and their local Medi-Cal Managed Care Plans (MCPs), conducted student behavioral health needs assessments and developed project plans for how SBHIP funds would be used. The SBHIP needs assessments offered recent, locally collected data on California students' most frequent behavioral health needs, LEAs' existing investments to support these needs, underserved student populations and mental and behavioral health disparities, barriers to addressing students' behavioral health, and additional supports that LEAs reported are necessary. The SBHIP project plans offer data on how LEAs were planning to invest SBHIP funding, how the planned interventions would increase access to behavioral health support, and how LEAs planned to sustain their new school-based health investments.
- » **Data from interviews with eight local leaders involved in the SBHIP.** The research team interviewed local SBHIP leaders from two COEs and four MCPs across California to learn more about the effectiveness of recent short-term funding initiatives in supporting school-based behavioral health, LEAs' plans for sustaining their school-based health investments, and the potential roles that health plans can play in supporting school-based behavioral health.

In addition, the research team reviewed findings from existing literature on systems to support school-based behavioral health in California from the past 3 years. The team also summarized the types of funding sources available for LEAs to use for behavioral health supports.

LEAs Fund Behavioral Health Supports by Cobbling Together Funds From Multiple Funding Streams

Although LEAs play an essential role in providing behavioral health supports to young people—and have expanded those supports substantially since the pandemic—LEAs do not have access to an ongoing funding source intended to cover the full breadth of supports needed by California's children and youth. Instead, LEAs and local partners braid and blend a number of different funding sources, which generally fall into three categories: short-term funding, ongoing education funding, and ongoing health care funding via Medi-Cal reimbursement.

Short-Term Funding: Pandemic Relief Funds and Recent State Initiatives

California LEAs' short-term funding sources include pandemic relief funds and recent state initiatives that focus on behavioral health supports. California's TK–12 schools have received approximately \$23 billion in federal funding and about \$18 billion in state funding to address student needs that began or were exacerbated by the COVID-19 pandemic (Legislative Analyst's Office [LAO], 2023). These funds are generally flexible in their allowable uses (LAO, 2023), so LEAs have frequently used these funds to expand both behavioral health and academic supports (Jordan & DiMarco, 2023; Krausen et al., 2023; Lafortune et al., 2023). However, most of this short-term funding ends in September 2024 (LAO, 2023).

As noted earlier, as part of its *Master Plan for Kids' Mental Health*, California has also made significant investments in school-based behavioral health through a variety of short-term initiatives, including the Mental Health Student Services Act (MHSSA), the SBHIP, and the CCSPP. Each of these short-term initiatives lasts from 2 to 5 years, and many are intended to support LEAs and local partners in launching systemic, long-term change efforts. However, systemic changes often require additional resources to sustain them beyond the initial short-term investment; furthermore, these short-term initiatives do not provide funding to all LEAs and schools across California.

Ongoing Education Funding

The main source of ongoing education funding in California is the Local Control Funding Formula (LCFF), which provides state funding for the vast majority of LEAs. Based on California's principle of "local control," LCFF base funds have flexible uses, but many educational priorities compete for these limited funds. Basic priorities include the costs to hire and retain qualified teachers and administrators, update learning materials and curricula, and provide academic interventions for students who need additional support. LEAs also receive special education funds that can help support behavioral health services for students with individualized education programs (IEPs) and some preventive services, but special education funds are insufficient to cover current special education costs in many LEAs, requiring LEAs to use LCFF and other general education funds to help pay for special education. Finally,

there are a few other specific federal funding streams, such as Title II and Title IV of the Every Student Succeeds Act (ESSA),³ which can support behavioral health services and programs; however, these funding streams are relatively small and restrictive in terms of their allowable uses and target student populations.

Ongoing Health Care Funding: Medi-Cal Reimbursement

LEAs and their health agency partners frequently identify Medi-Cal reimbursement as a key strategy for sustaining behavioral health services in school settings. However, Medi-Cal typically only covers Tier 3 and some Tier 2 services,⁴ only covers services provided to students enrolled in Medi-Cal, and has reimbursement rates based on a complicated set of factors that may not account for the total cost of a service. These are significant limitations given that school-based health services typically span Tiers 1 through 3 and are available to all students regardless of Medi-Cal or private insurance coverage. In addition, many LEAs face logistical and administrative challenges in billing Medi-Cal or partnering with community-based providers that can seek Medi-Cal reimbursement.

Reliance on Short-Term Funds and Ongoing Education Dollars Is Not a Sustainable Solution

With the influx of short-term funding, many LEAs have managed to braid and blend various funding sources to significantly enhance their internal school-based behavioral health supports. For example, many LEAs have hired additional school counselors and social workers and have spread the additional staffing costs across the SBHIP, Elementary and Secondary School Emergency Relief (ESSER), and MHSSA funding. However, LEAs vary in their capacity to braid and blend funding with ongoing resources—varying in terms of both their technical knowledge and their ability to access funds, particularly in the case of competitive grants.

Without an ongoing, dedicated, and flexible source of funding to address behavioral health needs for all students, LEAs will need to continue to leverage multiple funding streams to address students' needs. But LEAs cannot sustain or expand the necessary behavioral health investments on their own without making substantial reductions in other services.

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From the interviews with national experts on school-based health conducted for the *Ecosystem* paper (Breaking Barriers California,

³ ESSA reauthorized the Elementary and Secondary Education Act, which is the nation's main education law and provides funding for states to implement various education-related services. Title II covers preparation, training, and recruitment for school staff. Title IV provides funding to promote student health, increase access to a well-rounded education, and improve the use of technology.

⁴ Tier 1 supports are universal supports and include behavioral health activities designed to meet the needs of all students regardless of whether they are at risk for mental health problems. Tier 2 supports are targeted supports and include services and activities provided for students who have been identified as benefiting from more support. Tier 3 supports are individualized supports and include activities and services that are more intensive.

2023), school-based health experts agree that health plans, Medi-Cal, public health agencies, and health care providers have the opportunity and responsibility to take a much larger role in directly supporting school-based health efforts.

LEAs Described Both Workforce Needs and Structural Needs for Providing Sustainable School-Based Behavioral Health Support

Based on the analysis of SBHIP needs assessments, most of the investments that LEAs described as critical needs fell into two broad categories: workforce needs and structural needs.⁵ Workforce needs consisted of hiring staff (or, in certain cases, training existing staff) to provide a range of critical behavioral health supports for students. Structural needs consisted of local system infrastructure that would enable LEAs to collaborate with local partners to provide more behavioral health supports for students and improve the effectiveness and coordination of services.

Workforce Needs

In all of the counties' SBHIP needs assessments that were analyzed, LEAs described the need to expand their school-based behavioral health workforce to provide students with access to necessary services. LEAs' responses varied in terms of whether they needed more staff to focus on services within Tier 1 (universal supports), Tier 2 (targeted interventions), Tier 3 (intensive interventions), or a combination of tiers. LEAs reported using SBHIP funds to hire counselors, clinical social workers, family/student engagement liaisons, and student support specialists, among other roles. Notably, these priorities indicate that many LEAs prefer to hire behavioral health providers to work for the LEA rather than dedicating additional funding to contract out with community-based organizations or health care providers for services.

In addition to wanting to increase the quantity of dedicated behavioral health professionals, LEAs reported the need for a bilingual and/or more diverse behavioral health workforce that reflects California's linguistically and culturally diverse student population. This need echoes findings from other recent literature (Breaking Barriers California, 2023; Children and Youth Behavioral Health Initiative [CYBHI], 2023). LEAs also reported needing to invest in training existing staff, particularly classroom teachers, in Tier 1 strategies such as trauma-informed practices, social and emotional learning (SEL), restorative practices, behavior management, support for students with anxiety, and suicide prevention. Some LEAs also described the need to launch or expand peer-to-peer support programs, particularly for adolescents; students also have identified such programs as a high priority (Breaking Barriers California, 2023; CYBHI, 2023).

⁵ The main exceptions were facility needs (namely, the dedication of physical spaces for counseling or other behavioral health services and activities) and transportation needs for helping students access services off campus. However, these were identified somewhat less frequently as high-priority needs, and they represent smaller financial investments than the workforce and structural needs.

Structural Needs

The most frequent structural need reported by LEAs was the need to develop a *closed-loop referral system*. LEAs reported that after students receive a referral for external behavioral health services or other community-based supports, barriers often prevent students from receiving the needed services. These barriers include families opting not to pursue treatment for the student (whether due to mental health stigmas, transportation, or other challenges); external providers not making contact or following up; and lack of appointment availability. These challenges also contributed to some LEAs' preferences for hiring behavioral health staff internally. A closed-loop referral system—which would include a process and technical systems that enable LEAs to coordinate closely with external providers—would enable LEAs and their partners to provide case management for each student from start to finish, allowing them to intervene and offer support when students encounter barriers to accessing external services.

Along with noting the need for structural investments to improve LEAs' coordination with external partners, some LEAs described needing to invest in expanding their networks of external partners and improving their internal coordination of services. For example, some LEAs reported the need for (and/or plan to invest in) TA to establish and negotiate contracts with MCPs and other local partners; support for establishing data-sharing agreements and shared data systems; technical infrastructure for telehealth services; and greater internal LEA service coordination, such as Coordination of Services Team (COST) structures. Although LEAs rarely named Medi-Cal billing infrastructure as a priority in their needs assessments, LEAs' project plans identified Medi-Cal billing as their most frequent strategy for sustaining new behavioral health investments over the long term. Given that many LEAs currently lack Medi-Cal billing infrastructure (California Department of Education et al., 2021; Romer et al., 2022), these data suggest that Medi-Cal billing infrastructure is also a high-priority need for many LEAs.

Notably, within the sample of SBHIP needs assessments across 28 counties, structural needs were described much less frequently than workforce needs. It is possible that the needs assessment questions, which focused on students' behavioral health needs and the resources that LEAs needed to address them, prompted LEAs to focus more on programs and staffing. However, the research team noted this same prioritization of workforce expansion over structural investments in LEAs' SBHIP project plans (discussed later)—even though project plans focused on LEAs' concrete plans for investing SBHIP funds into sustainable behavioral health programs and infrastructure. In the interviews with state and national experts on behavioral health and school-based systems of care, structural investments were identified as an equally essential need, particularly when considering the sustainability of LEAs' services.

In Some Cases, LEAs Have Used Short-Term Resources to Lay a Foundation for Long-Term Partnerships and Integrated Systems of Care

A major goal of short-term behavioral health initiatives, including SBHIP and other CYBHI workstreams, has been to support LEAs and their partners in building long-term, sustainable, integrated systems of care for students. Accordingly, LEAs did report using some of their short-term resources for longer term structural investments aimed at enhancing the effectiveness of service delivery, lengthening their programs' sustainability, or both. For example, the uses reported in SBHIP project plans and interviews include

- » developing closed-loop referral systems;
- » expanding connections to external providers and community resources;
- » establishing structures for cross-agency collaboration (e.g., setting up MOUs and data-sharing agreements);
- » providing LEA and school staff with professional development (e.g., on SEL, trauma-informed practices, substance use prevention, suicide prevention) so that they are able to provide preventative education and other Tier 1 support; and
- » building infrastructure for billing Medi-Cal.

However, the analysis of SBHIP project plans found that LEAs most frequently reported leveraging their funds to expand behavioral health staffing and support services provided directly by the LEA rather than investing in partnerships and other structural investments. Interviewed COE and MCP leaders made similar observations. In other words, rather than investing in improving LEAs' collaboration with and students' access to external partners who have a long history of providing behavioral health support, LEAs more often used the funding to develop their own internal capacity to provide behavioral health support directly to students within their schools and districts.

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This observation mirrors recent research that found that LEAs reported spending substantially more of their pandemic relief funds on providing direct services to meet students' immediate needs than on structural investments to promote long-term systems change (Krausen et al., 2023). Expanding the number of staff that an LEA employs not only leads to sustainability concerns, as described below, but also can undermine the sustainability of the local child- and youth-serving system.

One of the trade-offs of LEAs hiring new behavioral health practitioners is that those practitioners often come from community-based organizations. As a result, those community-based organizations may face exacerbated workforce shortages and have even less capacity to serve young people outside of school time (such as summer and holiday breaks) or to serve young people not connected to school settings.

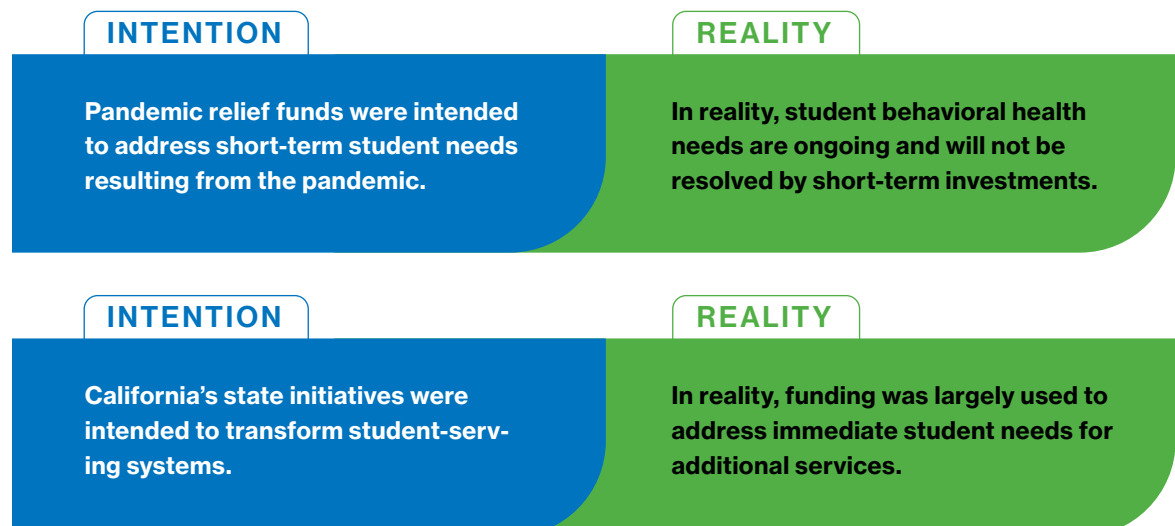
Flexible Use of Short-Term Behavioral Health Funding Has Allowed LEAs to Focus on High-Priority Needs

According to the analysis, LEAs have most frequently been using short-term behavioral health funding to expand supports to meet students' highest priority needs (described previously in the "Workforce Needs" section). In particular, COE and MCP leaders emphasized that the funding's flexibility was essential in allowing LEAs to invest in the highest priority resources for their individual contexts and school communities' needs. Based on the analysis of SBHIP project plans, LEAs' most frequent uses of SBHIP funds include

- » expanding LEAs' behavioral health workforces by hiring new staff,
- » partnering with families to reduce the stigma around student access to services,
- » establishing or expanding campus wellness centers, and
- » providing telehealth to students.

COE and MCP leaders noted that most LEAs have been expanding these behavioral health supports, with the exception of telehealth, by hiring additional LEA staff rather than by seeking external partners. One reason, the interviewed leaders explained, is that having behavioral health staff as LEA employees could help LEAs ensure that staff were equipped to work in school-based settings. Additionally, within SBHIP needs assessments, LEAs emphasized that external providers often had limited availability and long waitlists, and, unless external providers could travel to campus, transportation often presented a barrier for families. Consequently, hiring behavioral health staff as LEA employees offered a more reliable way to ensure that students could access services.

Intention Versus Reality of Short-Term Funding



Staffing and Program Expansions Prompt Sustainability Concerns

Although short-term funding has provided a valuable opportunity for LEAs to expand their behavioral health staffing—and, in some cases, invest in long-term structural supports—these investments have long-term cost implications, raising concerns about how to sustain them after short-term funding concludes.

Anticipating this concern, SBHIP project plans required that LEAs identify strategies to sustain their new programs after the initiative concludes. LEAs most frequently identified the following strategies:

- » billing Medi-Cal (through the new Multi-Payer Fee Schedule and the LEA Billing Option Program [LEA BOP])
- » using limited, existing LEA funds, such as LCFF funds, to pay for the new programs
- » applying for new grants

Leveraging Medi-Cal health care dollars to support school-based behavioral health services can help LEAs sustain behavioral health investments and help health agencies and health plans become more actively involved and invested in the provision of school-based health that improves health outcomes of children and youth. However, as described earlier, Medi-Cal billing alone is insufficient to sustain investments made using SBHIP and other short-term funds.

Although some important details about claiming requirements are forthcoming, the new Multi-Payer Fee Schedule does expand Medi-Cal and commercial coverage for some additional services and students, including privately insured students, beyond what is currently covered by the LEA BOP,⁶ which is California's existing program for reimbursing educational agencies for part of the cost of health services that they provide to Medi-Cal-eligible students. Nevertheless, Medi-Cal billing will still only cover certain services, and it will not fully cover the costs (i.e., the full salaries and benefits) of additional staff hired by LEAs to support students. One reason is that a portion of behavioral health staff's time is spent on nonreimbursable activities such as necessary administrative tasks and collaboration with other school staff. Additionally, the LEA BOP does not reimburse LEAs for the entirety of staff members' time that is spent delivering eligible services to eligible populations.⁷

Furthermore, many crucial Tier 1 services and programs, such as schoolwide prevention campaigns, student and family engagement, SEL, and trauma-informed classroom practices,

⁶ The LEA BOP was authorized in 1993 under California's Welfare and Institutions Code, section 14132.06.

⁷ The LEA BOP uses federal dollars to reimburse LEAs for 50 percent of the cost of a staff member's time that is spent providing eligible services to Medi-Cal-enrolled students, but LEAs must use nonfederal dollars to pay for the remaining 50 percent of eligible costs and 100 percent of noneligible costs. For example, if a school social worker's salary and benefits cost \$100,000 per year and she spends 40 percent of her time providing eligible services to Medi-Cal-enrolled students, then the LEA BOP would reimburse the school for \$20,000 (covering 20 percent of her time), and the school would have to use other funding for the remaining 80 percent.

cannot be funded through Medi-Cal billing. One MCP leader noted, “Any sustainability plan that begins with, ‘We’ll bill Medicaid’—I know it’s not going to work. You need to have a significant funding source beyond Medi-Cal or Medicaid.” In other words, to support the sustainable provision of a full suite of behavioral health services for students, LEAs will need to leverage ongoing sources of education funding for Tier 1 and some Tier 2 services while leveraging external partners and Medi-Cal billing options for expanded Tier 2 and Tier 3 services.

Additionally, schools and partners are cautious about—and need support implementing—the many logistical requirements of health care billing programs such as the LEA BOP and the Multi-Payer Fee Schedule. An MCP leader pointed out that the administrative requirements involved with Medi-Cal billing in particular present a barrier to smaller school districts’ participation. In California, small districts⁸ represent over half of the state’s school districts (California School Boards Association, 2022) and 91 percent of California’s rural districts (Vincent, 2018).

MCPs Have an Opportunity to More Actively Partner With Schools

One of the goals of the SBHIP is to incentivize Medi-Cal MCPs to actively support school-based behavioral health services for students. Specifically, SBHIP funds were distributed to participating MCPs—rather than to local education systems—and MCPs were required to partner with COEs and LEAs to help facilitate LEAs’ program participation. Interviewees acknowledged the mutual benefits of these partnerships; in particular, MCPs reported that the initiative expanded their understanding of and appreciation for school-based health. One MCP leader stated, “People [within my health care organization] are shocked to discover that schools have mental health providers. It blows my mind. So we have a lot more stories to tell now [after partnering with LEAs as part of the SBHIP] to help paint that picture. ... We can tell the patient’s journey within the school.”

The SBHIP’s goal of increased partnership between health plans and schools will be supported by other emerging state efforts pertaining to Medi-Cal, at least to some extent. One such effort is the Multi-Payer Fee Schedule (mentioned earlier), which will require health plans to reimburse school-based and school-linked providers for eligible services. In addition, new Medi-Cal health plan contracts include stronger language requiring deeper coordination with LEAs that provide health services in school settings.

Nevertheless, questions remain about the ongoing role and responsibilities of MCPs in contributing to school-based health services once the SBHIP ends in December 2024. Specifically, it is unclear to what extent MCPs will contribute ongoing financial or structural resources to

⁸ Small districts are defined as districts with an average daily attendance of less than 2,500 students.

supporting school-based efforts. MCP interviewees offered ideas for how their organizations might do so, but they reported that this question was still being discussed internally.

Recommendations for MCPs

Beyond following the new state requirements, MCPs could take a number of steps to actively support partnerships between school-based health providers and LEAs beyond when the SBHIP ends. These include the following:

- » Direct or incentivize the MCP's existing networked providers to support school-based activities. Although ideally this would have occurred as part of the SBHIP, ongoing efforts to expand student access to health plans' networked providers could help address LEAs' urgent need to expand their mental health workforce while avoiding the sustainability concern of bringing on large numbers of new LEA employees.
- » Provide TA to the MCP's existing in-network providers, focusing on best practices for integrating their services into school settings. For example, TA could include training practitioners on how to provide appropriate care to child and adolescent populations and on how to develop a practice model that provides time for providers to coordinate care and services with LEA and school staff.
- » Bring case managers and care coordinators who are employed or contracted by the health plan to school settings to support student access to covered services. This would help address some of the barriers to accessing services faced by students and families when services are provided outside of the school site (e.g., lack of transportation, lack of communication from providers, and lack of follow-through from families).
- » Directly fund school-based prevention work through grant-making, including through MCPs' required Community Reinvestment funds.⁹

Recommendations for State and County Leaders

The SBHIP and other short-term school behavioral health initiatives have laid the groundwork for stronger partnerships between LEAs and health care partners to address the behavioral health of students. Yet continued efforts are needed to strengthen these partnerships and clearly delineate the fiscal responsibilities of education and health system entities in sustaining integrated school-based behavioral health services and programs.

In an integrated system of behavioral health, schoolwide programs (Tier 1) and some limited targeted interventions (Tier 2) are the strengths of LEAs and should be the education

⁹ As of 2023, MCPs and their fully delegated subcontractors with positive net income are required to allocate 5 to 7.5 percent of these profits (depending on the level of their profit) to local community activities that develop community infrastructure to support Medi-Cal members (California Department of Health Care Services, n.d.).

system's fiscal and implementation responsibility. Targeted and more intensive services (Tiers 2 and 3) are challenging for LEAs to sustain and offer more opportunity for the health system to provide funding.¹⁰ When feasible, Tier 2 and Tier 3 services, regardless of whether they are funded by health care partners, could still be offered at the school site to mitigate barriers to access.

Below are some recommendations for how the state, COEs, and health plans can continue to drive integration between education and health care toward sustaining the interventions launched to address student behavioral health.

Continue to strengthen MCPs' contractual responsibilities to LEAs.

The Department of Health Care Services and Department of Managed Care (responsible for the oversight of Medi-Cal and commercial health plans in California) should monitor MCP support and coordination with school partners to ensure continuation beyond the conclusion of the SBHIP. New contract language strengthens the MCP role in coordinating with schools, and the fee schedule forces a financial commitment to support school-based services. However, the state must develop accountability mechanisms to evaluate and confirm the extent to which these policies are increasing access to services and improving student behavioral health outcomes.

Such mechanisms could include monitoring health plans for evidence of improved coordination of health services with all LEAs in the MCP's region and monitoring paid and rejected claims through the fee schedule.

Structure future funding, TA, and policy changes in ways that incentivize schools to strengthen partnerships with external behavioral health providers.

Each health plan contracts with a network of community-based practitioners (e.g., clinics, individual clinicians, hospitals) that are responsible for delivering care to covered patients. Most of these practitioners, if not all, are already responsible for providing preventive and integrated health care to children and youth who are covered by the health plan, and many have experience partnering with schools to provide school-based and school-linked services for students.

Unfortunately, as noted earlier, many LEAs reported challenges with referring students to external providers, including limited availability, lengthy waitlists, and transportation barriers

¹⁰ Exceptions include special education services and related supports provided to eligible students under the Individuals with Disabilities Education Act (IDEA); LEAs are legally responsible for providing these services and supports.

for families. These are important concerns to address—but, based on SBHIP data and interview data, LEAs are instead simply relying less on external providers and focusing more on hiring internal behavioral health staff.

However, leveraging community-based providers can bring access to sustainable funding through health plan billing that LEAs may lack, and as contractors of health plans, these providers can help strengthen partnerships between health plans and schools. Given some LEAs' understandable reluctance to rely on external providers, future state initiatives should continue to explicitly aim to establish and strengthen partnerships between LEAs and external behavioral health providers, including by improving coordination systems and incentivizing practitioners to provide services on school campuses.

Help LEAs and their local partners adjust their expectations about Medi-Cal and health care billing.

Schools and school-linked behavioral health partners should be doing everything possible to bring in health care dollars to support the health services delivered in school settings. Access to services in school settings improves health outcomes that health care payers (i.e., health plans, hospitals, health and public health departments) care about (Sanchez et al., 2018). Consequently, when health care funding plays a larger role in supporting school-based health, everyone wins. However, sustaining integrated school-based behavioral health services will not be accomplished through billing alone (e.g., via the LEA BOP or Multi-Payer Fee Schedule).

Thus, although state and county leaders should encourage LEAs to participate in health care billing programs and not leave dollars on the table, they should aim to ensure that LEAs have realistic expectations about the degree to which health care billing might contribute to an LEA's overall behavioral health funding. That is, they should communicate that health care billing is an important piece of the puzzle and in many cases should become a larger piece of LEAs' sustainability plans—particularly with the greater service coverage offered by the

Multi-Payer Fee Schedule—but it is not a silver bullet for funding school-based behavioral health services.

Accordingly, LEAs may want to consider focusing their available funding on a limited set of services, particularly preventative and Tier 1 support, and strengthening access to networks of community-based practitioners for Tier 2 and Tier 3 services.

That is, they should communicate that health care billing is an important piece of the puzzle and in many cases should become a larger piece of LEAs' sustainability plans—particularly with the greater service coverage offered by the Multi-Payer Fee Schedule—but it is not a silver bullet for funding school-based behavioral health services.

Conclusion

As most pandemic funding for schools comes to an end, California's leaders have reached a critical moment. LEAs have used California's historic investments in school-based behavioral health to expand supports for students. Short-term initiatives such as the SBHIP have helped LEAs lay a foundation for partnerships with health care organizations and other cross-sector partners. The state's development of the Multi-Payer Fee Schedule offers the opportunity for the health care system to play a greater role in resourcing school-based health, as long as LEAs have the infrastructure to fulfill billing requirements.

LEAs cannot fund school-based health on their own, and given the numerous players within the health care system who carry a shared responsibility for supporting positive health outcomes for youth, LEAs should not be expected to go it alone. However, local partnerships between health and education systems are largely still in their infancy. With California's near-future economic outlook offering less room in the state budget to invest heavily in LEAs, state leaders must think strategically about how to structure funding in a way that promotes sustainability.

But through policy shifts, TA, and investment in additional strategic initiatives that strengthen partnerships between local education systems and health care partners, California's leaders have a powerful opportunity to make school-based behavioral health systems stronger and more sustainable—and to avoid the risk of schools needing to slash critical behavioral health supports as short-term funding comes to a close.

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